STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE		(X3) DATE SURVEY	
		A. BUILDING 00		COMPLETED	
155689		B. WING		01/27/2015	
NAME OF PROVIDER OR SUPPLIER					
(ADD LIEAL THOAF	OF OFNITED				
YARD HEALTHCAF	RECENTER	GOS	6HEN, IN 46526		
		ID			
` `	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	COMPLETION DATE	
REGULATORT OF	CESC IDENTIFY TING INFORMATION)	IAG		DAIL	
This visit was for Complaint #INO Complaint #INO Federal/State de allegation are cited Survey dates: Jack Facility number Provider number AIM number: 10 Survey team: Shauna Carlson, Pamela William Amy Miller, RN Census bed type SNF: 14	or the Investigation of 00163088.  00163088 - Substantiated.  officiencies related to the ted at F-323.  unuary 26 & 27, 2015  : 000091  r: 155689  00290080  , RN - TC  ss, RN	F000000	for our Recertification and Si Licensure with Complaint Su conducted on 1/27/2015. Submission of this Plan of Correction is not an admission Courtyard Healthcare Cente the deficiencies alleged in the survey are accurate or that the depict the quality of nursing and services provided to the residents of our facility. This of Correction is being submissolely because doing solely	liance tate urvey on by r that e hey care s Plan tted	
Total: 162					
Census payor ty Medicare: 13 Medicaid: 106 Other: 43 Total: 162 Sample: 3	pe:				
	PROVIDER OR SUPPLIED YARD HEALTHCAF  SUMMARY S (EACH DEFICIENT REGULATORY OF This visit was for Complaint #INO Complaint #INO Federal/State de allegation are cit Survey dates: Jat Facility number Provider number AIM number: 10 Survey team: Shauna Carlson Pamela William Amy Miller, RN Census bed type SNF: 14 SNF/NF: 148 Total: 162 Census payor ty Medicare: 13 Medicaid: 106 Other: 43 Total: 162	PROVIDER OR SUPPLIER YARD HEALTHCARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  This visit was for the Investigation of Complaint #IN00163088.  Complaint #IN00163088 - Substantiated. Federal/State deficiencies related to the allegation are cited at F-323.  Survey dates: January 26 & 27, 2015  Facility number: 000091 Provider number: 155689 AIM number: 100290080  Survey team: Shauna Carlson, RN - TC Pamela Williams, RN Amy Miller, RN  Census bed type: SNF: 14 SNF/NF: 148 Total: 162  Census payor type: Medicare: 13 Medicaid: 106 Other: 43 Total: 162	OF CORRECTION   IDENTIFICATION NUMBER:   155689   S. WING     PROVIDER OR SUPPLIER   STREE   2400   GOS	DENTIFICATION NUMBER: 155689  R WING  PROVIDER OR SUPPLIER  VARD HEALTHCARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL. REGULATORY OR LSC IDENTIFYING INFORMATION)  This visit was for the Investigation of Complaint #IN00163088.  Complaint #IN00163088 - Substantiated. Federal/State deficiencies related to the allegation are cited at F-323.  Survey dates: January 26 & 27, 2015  Facility number: 000091 Provider number: 155689 AIM number: 100290080  Survey team: Shauna Carlson, RN - TC Pamela Williams, RN Amy Miller, RN  Census bed type: SNF: 14 SNF/NF: 148 Total: 162  Census payor type: Medicaid: 106 Other: 43 Total: 162  TID ROWIDES RLANG CORRECTION COSHEN, IN 46526  ID ROWIDES RLANG CORRECTION COSHEN, IN 46526  ID ROWIDES RLANG CORRECTION COSHEN, IN 46526  FREETA ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526  ID ROWIDES RLANG CORRECTION COSHEN, IN 46526  FROODOO  Please accept this Plan of Correction as our facility's Credible Allegation of Comploint Succeptification and St Licensure with Complaint Succeptification is not an admission of this Plan of Correction is not an admission of this Plan of Correction is not an admission of this Plan of Correction is not an admission of this Plan of Correction is not an admission of this Plan of Correction is not an admission of this Plan of Correction is of the succeptification and St Licensure with Complaint Succeptification and St Licensure with Complaint Succeptification and St Licensure with Complaint Succeptification of Correction is not an admission of this Plan of Correction is not an admission of this Plan of Correction is not an admission of this Plan of Correction is not an admission of this Plan of Correction is not an admission of this Plan of Correction is not an admission of this Plan of Correction is not an admission of this Plan of Correction is not an a	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000091

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

AND PLAN OF CORRECTION    155689   155689     155689	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER  COURTYARD HEALTHCARE CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.  Quality Review completed on February 3, 2015, by Brenda Meredith RN.  F000323 SS=D FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  Based on interview and record review, the facility failed to provide adequate supervision and assistance while dining  F000323 F323 FREE OF ACCIDENTS/HAZARDS/SUPER WISION/DEVICES The facility failed to provide adequate supervision and assistance while dining				00		
COURTYARD HEALTHCARE CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY)  This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.  Quality Review completed on February 3, 2015, by Brenda Meredith RN.  FO00323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  Based on interview and record review, the facility failed to provide adequate supervision and assistance while dining  FO00323 F323 FREE OF ACCIDENTS/HAZARDS/SUPER VISION/DEVICES To ACCIDENTS/HAZARDS/SUPER VISION/DEVICES ACCIDENTS/HAZARDS/SUPER VIS			100000		ADDRESS CITY STATE ZIR CODE	01/21/2010
COURTY-RD HEALTHCARE CENTER  CAN ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.  Quality Review completed on February 3, 2015, by Brenda Meredith RN.  COMPLETION DATE  PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.  Quality Review completed on February 3, 2015, by Brenda Meredith RN.  FOUND 23  FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to provide adequate supervision and assistance while dining  FOUND 23  FREE OF ACCIDENTS/HAZARDS/SUPER MISION/DEVICES The facility failed to provide adequate supervision and assistance while dining  FOUND 23  FOUND 24  FREE OF ACCIDENTS/HAZARDS/SUPER MISION/DEVICES Facility will ensure that the	NAME OF P	PROVIDER OR SUPPLIER				
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.  Quality Review completed on February 3, 2015, by Brenda Meredith RN.  F000323 SS=D  FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to provide adequate supervision and assistance while dining  F000323  F000323 F000323 F323 FREE OF ACCIDENTS/HAZARDS/SUPER VISION/DEVICES The facility failed to provide adequate supervision and assistance while dining  F000323 F000323 F323 FREE OF ACCIDENTS/HAZARDS/SUPER VISION/DEVICES Facility will ensure that the	COURTYARD HEALTHCARE CENTER					
TAG REGULATORY OR LOS IDENTIFYING INFORMATION)  This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.  Quality Review completed on February 3, 2015, by Brenda Meredith RN.  F000323 SS=D  483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to provide adequate supervision and assistance while dining  TAG  CROSS-REFERENCED TO THE APPROPRIATE DATE  TAG  TAG  CROSS-REFERENCED TO THE APPROPRIATE DATE  TAG  TAG  CROSS-REFERENCED TO THE APPROPRIATE DATE  TO TAG  TAG  TAG  TAG  TAG  CROSS-REFERENCED TO THE APPROPRIATE DATE  TO TAG  TAG  TAG  TAG  TAG  TAG  TAG  TAG					PROVIDER'S PLAN OF CORRECTION	` '
This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.  Quality Review completed on February 3, 2015, by Brenda Meredith RN.  F000323 SS=D FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to provide adequate supervision and assistance while dining  F000323 F323 FREE OF ACCIDENTS/HAZARDS/SUPER VISION/DEVICES Facility will ensure that the		`			CROSS-REFERENCED TO THE APPROPRIA	ATE
for 1 of 3 residents sampled. (Resident B)  Finding includes:  resident environment remains as free of accidents, hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent	TAG	This deficiency recited in accordant 16.2-3.1.  Quality Review (2015, by Brenda 2015, by Brend	eflects state findings are with 410 IAC  completed on February 3, Meredith RN.  ENT RVISION/DEVICES nsure that the resident ins as free of accident sible; and each resident is supervision and is to prevent accidents. ew and record review, it to provide adequate assistance while dining ints sampled. (Resident B)	TAG	F323 FREE OF ACCIDENTS/HAZARDS/SUPIVISION/DEVICES Facility will ensure that the resident environment remains free of accidents, hazards as possible; and each resident receives adequate supervision	DATE  02/26/2015  ER  as is is in
The clinical record for Resident B was accidents.  reviewed on 1/26/15 at 1:45 P.M.  Corrective action to be						
reviewed on 1/26/15 at 1:45 P.M.  Resident B's record indicated an  Corrective action to be accomplished for resident						
admission date of 12/24/14. The found to be affected by the					found to be affected by the	
diagnoses included but were not limited deficient practice:					-	
to, "dysphasia, paralysis agitans,  The affected resident was discharged and no longer resides						des
muscle weakness, end stage renal disease at facility. How other residents		muscle weakness	s, end stage renal disease		at facility. How other residen	
on dialysis mon/wed/fri, diabetes, chronic having the potential to be		on dialysis mon/	wed/fri, diabetes, chronic			,
pain syndrome, glaucoma, late effect  affected by the same deficient practice will be identified and		pain syndrome, g	glaucoma, late effect		-	<b>I</b>

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A DITH DING 00		COMPLETED			
	155689		A. BUILDING B. WING 01/27/20			2015	
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
			2400 COLLEGE AVE				
COURTY	ARD HEALTHCAR	RE CENTER		GOSHEN, IN 46526			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATF	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	cerebrovascular	disease, previous			what corrective action(s) will	I	
	stroke"	, <b>1</b>			be taken:		
	5010110				All residents residing in the fa		
	A D1	' 1' / 1 U DT			have the potential to be affect		
	<u>-</u>	er indicated "PT			An evaluation will be performed		
	[physical therap	y] / OT [occupational			by either an LPN or an RN or	1	
	therapy] to eval	[evaluate] and treat			every resident infacility to		
	effective 12/24/	14"			evaluate each resident's abilit	· .	
					eat and drink at their current I of assistance, and assess the		
	Dogidant D'a gar	e plans indicated "Focus:			need for changes to assistive	1	
		•			devices or level of meal		
	Resident is legally blind r/t [related to]				supervision and		
	glaucoma. Date initiated:				assistance. (Attachment A)		
	12/30/14Interventions: anticipate				An evaluation of all new resid	ents	
	needskeep all items in rooms within				will be performed by either ar		
		in the same placemeds			LPN or an RN to determine th		
	as ordered"	in the sume placemeas			level of assistance needed wi	th	
	as ordered				eating and drinking. Each ne	w	
	A Nursing Progress Note, dated 1-2-15 at 7:25 A.M., indicated "Nurses Note:Resident was in dining room and spilled coffee in lap. Resident taken back to room no redness or warmth noted. Resident laid down. No complaints of pain", signed by LPN (Licensed Practical Nurse) #3.  A Nursing Progress Note, dated 1-2-15 at 9:27 A.M., indicated "Nurses Note: Area where coffee spilled checked				resident will be evaluated for		
					total of three meals, in order t		
					obtain a broad picture of how		
					resident eats/drinks at differen	-	
					times of the day. (Attachmen		
					What measures will be put in place or what systemic	nto	
					changes will be made to		
					ensure that the deficient		
					practice does not recur:		
					Dining Room Procedure		
					(Attachment C) was revised to	,	
					provide more specific guidelir		
					for CNAs and Nurses providir		
					assistance to residents during	•	
	Note:Area where coffee spilled checked no redness noted at this time. No				meal service.		
					Dining Room Procedure		
	complaint of pai	n at this time", signed			(Attachment C) was revised to		
	by LPN #3.				provide more specific guidelir	nes	
					for Restorative Manager		
	On 1-27-15 at 1	2:50 P.M., an interview			supervising staff providing		
					assistance to residents who r		
	was conducted with LPN #3. LPN #3				either hands on assistance or		

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED	
	155689		B. WIN		· · · · · · · · · · · · · · · · · · ·	01/27/	2015
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					OLLEGE AVE		
COURTYARD HEALTHCARE CENTER				EN, IN 46526			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		1	ID I			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)			CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		sident B] was on my			verbal cueing during meals.		
	_	dialysis 3 times a week,			Dining Room Timeline		
					(Attachment D) was created to	)	
		at 10 A.M., and usually			provide staff members a clear		
		ntil after 6 P.M We sent			timetable for when they should		
	_	gency room early			in the Dining Room and providing		
	morning on 1-3-	15 for a temperature of			assistance. Nursing Staff Meal Procedure		
	104.8 here and a	ltered mental			(Attachment E) was revised to		
	statusEarlier ir	n the day there had been			provide more detailed instructi		
	an incident in the	e main dining room			for Nursing staff who are		
	where he spilled coffee on his groin areaThey brought him to me and I				assisting with meal services.		
					All staff responsible for assisting	ng	
	immediately took him in his room,				with meal service will be		
	removed his pants and briefs, and				educated regarding Dining Ro Procedure and Dining Room	Om	
	•	· ·			Timeline.		
		for burnsI didn't see			All nursing staff will be educate	ed	
	anything, it was				on revised Nursing Staff Meal		
	anythingI assessed him again 2 hours later before he left for dialysis that day and still didn't see anything"				Procedure. How will the		
					corrective actions will be		
					monitored to ensure the		
					deficient practice will not rec	ur,	
	On 1-27-15 at 3:20 P.M., an interview was conducted with the Executive Director (ED). The ED indicated he was aware of the incident of Resident B spilling coffee on himself. "He ended up going to the hospital early the next				i.e., what quality assurance		
					program will be put into plac Director of Nursing, or her	e.	
					designee, will perform supervis	sion	
					/audit of meal service, includin		
					Restorative Dining. This will		
					include ensuring that residents	3	
					needing assistive devices,		
	_	inrelated issueI believe			assistance to eat, supervision cueing are receiving the	or	
	*	iaI did not know he			appropriate devices and level	of	
	was blind"				supervision and assistance. T		
					supervision will take place		
	On 1-27-15 at 3:	45 P.M., an interview			according to the following		
	was conducted v	with the Medical Director.			timeline: 10 meals per week for		
		rector indicated she had			period of 2 weeks; then 5 mea		
		Resident B's spills on			per week for a period of 2 wee	eKS;	
		#3. "she [LPN #3] told			then 2 meals per week for a period of 1 month; then 1 mea	la	
	1-2-13 Uy L1 IN †	75siic [Li 1\ #5] Wid				ıa	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 COMPLET			ETED		
155689		A. BUII B. WIN			01/27/	2015	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				OLLEGE AVE			
COURTYARD HEALTHCARE CENTER				EN, IN 46526			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
		nt was negative, so I			week for a period of 4 months, a total audit period of six mont		
	didn't come look	at him myselfI do			Director of Nursing, or her	115.	
	know he was bli	nd they would have to			designee, will utilize the "Meal		
	help him with ea	ting and drinking"					
	help him with eating and drinking"  On 1-27-15 at 3:50 P.M., an interview was conducted with OT (Occupational Therapist) #5. OT #5 indicated OT had been requested to evaluate Resident B and see what kind of assistance he needed while eating. "I did the evaluation with him on 12-30-14He had right sided weaknessHe was moderate assist, meaning he couldn't do a lot for himself. He could grab finger foods with his left hand and bring it to his mouth but with his right he had a hard time following through to his mouth. He tried to drink with his right hand. There was a lot I had to do for himI do know			Service Audit" (Attachment F) to perform and document the preceding audit/supervision. Summary of Meal Service Audit Results will be reported to Quality Assurance/Performance Improvement (QAPI) committee monthly for a period of 6 months for review.			
	· · · · · · · · · · · · · · · · · · ·	e use the clock method to					
	tell residents where their food and drinks are on the table, he had a hard time listening to his own instructions, he would listen to other residents instructions and get confused"						
	msu uctions and	get confused					
1		05 P.M., an interview					
		vith RN (Registered					
	Nurse) #6. RN #	6 indicated "I am the					
	restorative nurse	and I oversee the					
	assisted section	of the dining room at					
	breakfast. I do re	emember the morning he					
	spilled coffee on	himselfI immediately					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/19/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 01/27/2015		
NAME OF PROVIDER OR SUPPLIER  COURTYARD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	brought him down to his unit and gave him to LPN #3 to assessI did not know he was blindI do not know how therapy assessed him for eating needshe did not have a precautions cardand that info [assistance level] is not on their meal ticketWe do not get info or a report from therapy"  This Federal tag relates to Complaint IN00163088.  3.1-45(a)(2)							

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